

WALTER REED ARMY MEDICAL CENTER CENTER FOR REFRACTIVE SURGERY

Instructions for Completing the Refractive Surgery Referral Form.

1. Please print all your personal information on the top portion of the form.
2. Please use your complete numeric MOS. Simply saying "armor" is not sufficient.
3. Please make sure that the email address you provide is one that you regularly use.
4. Take the form to your local Optometry Clinic and ask the Optometrist to complete the bottom section concerning your vision and current prescription.
5. Fax the completed form to the Center for Refractive Surgery (CRS) at 202-782-4653 together with your Commanders Endorsement and Deployment Statement (if required).
6. If you have any questions please call CRS at 202-782-0202 / 0204 (DSN 662-0202 / 0204) Monday through Friday between 0800 and 1530. Holidays excepted.

REFRACTIVE SURGERY REFERRAL FORM

Patient Name: _____ Rank: _____ SSN: _____

Unit: _____ (MOS): _____

Phone: (W) _____ (H) _____

Age: _____ Date: _____

Contact Lens History: _____

NOTE: CONTACT LENSES MUST BE OUT FOR TWO WEEKS BEFORE THE PRE-OP EXAMINATION.

EXCLUDE patients with a "YES" answer to any of the following:

- History of keratoconus? Yes/No
- Pregnant or nursing? Yes/No/NA
- Change in refraction MORE than 0.50 Diopters in the past year? Yes/No

PATIENTS SHOULD FIT ONE OF THE FOLLOWING REFRACTIONS:

- Myopia: -1.0 to -10.00 diopters
- Myopia with Astigmatism: 0 to -10.00D myopia up to 4.00D astigmatism
- Hyperopia (symptomatic!): +1.0 to +6.0 D with no more than 4.00D of astigmatism

1. **SOLDIERS MUST HAVE WRITTEN PERMISSION FROM THEIR COMMANDER TO GET THIS SURGERY. SOLDIER WILL BE NON-DEPLOYABLE FOR UPTO 90 DAYS AFTER SURGERY, TYPICALLY 30 DAYS.**
2. **THE SOLDIER MUST HAVE A MINIMUM OF 18 MONTHS ACTIVE DUTY SERVICE COMMITMENT FROM THE TIME OF SURGERY.**
3. **SPECIAL OPERATIONS SOLDIERS MAY GET PRK BUT NOT LASIK, PER DIRECTION OF THE USASOC SURGEON. SPECIAL OPS SOLDIERS HAVE PRIORITY FOR PRK.**
4. **PRK PATIENTS WILL NOT PARACHUTE, DRIVE MILITARY VEHICLES, OR PARTICIPATE IN NIGHT OPERATIONS FOR 30 DAYS AFTER SURGERY.**
5. **LASIK PATIENTS MAY NOT PARACHUTE FOR 1 MONTH AND MUST WEAR PROTECTIVE EYEWEAR FOR THE FIRST MONTH POST-OP WHEN IN THE FIELD.**
6. **NATIONAL GUARD AND RESERVES ARE NOT ELIGIBLE FOR TREATMENT UNDER THE WRESP EXCEPT FOR AGR PERSONNEL.**

	OD	OS
1. Current Glasses Rx (REQUIRED)	_____ - _____ x _____	_____ - _____ x _____
2. Manifest Refraction (if performed)	_____ - _____ x _____	_____ - _____ x _____
3. Best Corrected VA	20/_____	20/_____

FAX THIS FORM TO THE WALTER REED CENTER FOR REFRACTIVE SURGERY AT 202-782-4653. For more information call 202-782-0202 / 0204.

Examining Provider: _____